Abstracts of State Legislated Hospital Cost Containment Programs

U.S. Department of Health, Education, and Welfare
Health Care Financing Administration
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ABSTRACTS OF

STATE LEGISLATED HOSPITAL

COST CONTAINMENT PROGRAMS

MAY 1978

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
OFFICE OF POLICY, PLANNING, AND RESEARCH
OFFICE OF DEMONSTRATIONS AND EVALUATIONS

CONTENTS

FOREWORD

The intent of this report is to present a summary of State efforts to control rising hospital costs. The abstracts which follow focus on legislated programs requiring the disclosure, review, or regulation of hospital rates and budgets and represent the status of these efforts as of April 30, 1978. The abstracts summarize key legislative features and operating aspects of each State program. A glossary of terms is located at page 62.

This report was prepared by the staff of the Hospital Rate Regulation Branch, Office of Demonstrations and Evaluations, Office of Policy, Planning, and Research, Health Care Financing Administration, as part of our ongoing effort to disseminate information on cost containment activities. The staff of the Hospital Rate Regulation Branch includes Al Esposito (Branch Chief), John Gillespie, Howard Jackson, John Jasin*, Steven Pelovitz, and Stafford Sutton. A special thanks to John Jasin who compiled a substantial portion of this report, to Stafford Sutton who spent considerable time contacting individuals at the State level, and to Mary Griffin, the branch's secretary.

* An employee of the New Jersey State Department of Health currently working with the Hospital Rate Regulation Branch on an Intergovernmental Personnel Action.

We also extend our gratitude to the legislative reference services and those individuals in each State who have willingly provided us with their valuable time and copies of legislation and pending bills.

James M. Kaple
Acting Assistant Administrator
for Demonstrations and Evaluations
Office of Policy, Planning, and Research

SUMMARY

As of April 1978, fifteen States had enacted legislation which requires the disclosure, review, or regulation of hospital rates or budgets. Table 1 summarizes the major characteristics of each program. Of the fifteen programs, eight (California, Colorado, Connecticut, Maine, Maryland, Massachusetts, Virginia, and Washington) are based in independent commissions or boards whose members are representative of various provider and consumer interests. Five of these programs (Colorado, Connecticut, Maryland, Massachusetts, and Washington) have rate setting commissions with full authority to review and approve hospital budgets or rates. Maine and Virginia have recently created a State board and a commission with authority to review and comment publicly on the reasonableness of a hospital's costs and charges or to designate a voluntary review organization to conduct such reviews. California has a commission with authority only to require disclosure of hospital financial data. The remaining seven programs are based in State agencies. New Jersey and New York perform the review directly and have authority to set Medicaid and Blue Cross rates. Arizona and Oregon also perform the review directly but only comment on the reasonableness of proposed rates with no enforcement authority. Minnesota, Rhode Island, and Wisconsin each operate through other organizations or committees. The Minnesota program is carried out substantially by the State hospital association and requires budget review but voluntary compliance with the findings. The Rhode Island program is carried out by Blue Cross, and Wisconsin uses a joint committee

representing the Department of Health, Blue Cross, and the State hospital association. Both the Rhode Island and Wisconsin programs require compliance with the findings of the review process.

Participation in each of the fifteen programs is mandatory for all non-governmental hospitals. Compliance with the findings of the fourteen budget and rate review programs is mandatory in nine programs and voluntary in Arizona, Maine, Minnesota, Oregon, and Virginia. It should be noted that States with voluntary compliance believe that public pressure and third-party contractual payment processes encourage hospital compliance.

The majority of the States operate budget review programs. New York is the only State which does not review hospital budgets when setting hospital rates. Massachusetts uses a rate setting process similar to New York's in establishing a Medicaid rate. The Maryland program requires annual filings of budget data but operates more as a public utility commission. A detailed budget review may be requested by the hospital or initiated by the commission. Arizona and Wisconsin require budgets, rate information, and other financial data only when an increase is requested.

The type of rate approved and the extent to which these rates apply to purchasers vary substantially. Maryland is the only State in which all purchasers pay on the basis of charges which are set at a level to meet commission approved rates. The rates in Washington apply to all

purchasers in two-thirds of their hospitals under an experiment supported by the Office of Demonstrations and Evaluations, Office of Policy, Planning, and Research, HCFA. Hospitals have been randomly assigned to one of three groups. For the first group the commission sets a total revenue figure. The second and third groups have a fixed approved rate per unit of service. The first and second groups' rates apply to all purchasers and the third group's rates apply only to charge-based payors. In each group charges are the basis of payment and are set at a level to meet commission approved rates. Wisconsin and Colorado rates apply to all but Medicare and Medicaid. New Jersey and New York rates apply to Medicaid and Blue Cross and are all-inclusive per diems. Massachusetts sets different rates for Blue Cross, Medicaid, and charge-based payors under three separate review systems. In the remaining States payor coverage is limited to some combination of Blue Cross, and/or Medicaid, and/or charge-based payors.

Most programs allow for appeals. Arizona and Oregon have no formal appeals process since compliance is voluntary. Most programs specify the circumstances under which adjustments will be made to their rates. In Oregon, Arizona, Minnesota, Wisconsin, and the charge-based program in Massachusetts, rate changes may be requested during the hospital's fiscal year. In New York the only adjustment is for actual economic factors. In Maryland and the Massachusetts Blue Cross and Medicaid program, changes are possible for uncontrollable costs. New Jersey makes adjustments for volume, economic factors and prescribed pass-through items. Other States adjust for volume and unusual and unforeseen circumstances.

Several States are involved in developmental activities funded through the Office of Demonstrations and Evaluations, Office of Policy, Planning, and Research, HCFA. These efforts include research on developing comprehensive data systems and per admission based reimbursement systems (New York), efforts to develop refined methods to adjust for the fixed and variable costs of volume changes (Connecticut), efforts to develop methodologies for comparing hospitals on a departmental basis (Massachusetts), and the development of a methodology to pay for hospital admissions on a diagnosis specific basis (New Jersey).

There appears to be a trend in prospective payment programs to systems which consider the total revenue of the hospital rather than total expenses. There also appears to be a trend towards setting aggregate rates such as a rate per unit of service by department which is used as a basis for itemized charges set by a hospital to generate these rates. Budget reviews continue to be the predominant method used for determining the reasonableness of costs. However, most programs use an exceptions process which results in little if any review for a hospital whose costs are lower than its peer group average cost or whose increase in costs or rates is less than its peer group average increase or a prescribed percentage increase.

The newer statutes tend to be very detailed and prescribe explicitly those items which may or may not be considered during a review.

Colorado's legislation for example allows the commission to use population-based statistics on medical care as a criteria for review and requires the commission to comment on the financial implications of all capital expenditures projects requiring review by the "State Certificate of Public Necessity Act." The Colorado legislation also defines health care services to include salaries paid to physicians but excludes physician's fees for services. In contrast, earlier statutes such as Maryland's are still being interpreted by the courts. Recently the courts ruled that the Maryland Health Services Cost Review Commission has the authority to set rates for hospital based physicians whether on salary or not.

There is a considerable amount of discussion ongoing in many States throughout the U.S. concerning hospital budget/rate review and rate setting programs. These discussions have intensified significantly since the introduction of the various hospital cost containment proposals at the federal level, which allow for exceptions to States that have established cost containment programs which meet certain criteria. In addition, the Voluntary Effort announced by the American Hospital Association has encouraged further discussions at the State level.

Table 2 attempts to summarize the current legislative activity in the hospital cost containment area in each of the 50 States. It should be noted that it is difficult at best to precisely describe the potential for passage of a bill in a State. For example, the introduction of a

bill does not indicate the level of support for the legislation. In addition, passage of a bill requiring budget/rate review without approval authority would likely be less difficult than a bill granting rate setting authority. We have attempted only to indicate activities which can be classified as "beyond the discussion phase." This does not necessarily indicate that States without such activity are any less likely to pass legislation.

Table 1

FIFTEEN STATE LEGISLATED HOSPITAL COST CONTAINMENT PROGRAMS

State	Responsible Agency	Type of System	Voluntary vs. Mandatory	Payors Covered	Revenue Control Method	Unit of Payment	Frequency of Review	Adjustments	Appeals
Arizona	Department of Health Services: local HSAs	Budget/Rate Review	Mandatory Review Voluntary Compliance	Charge-based including Blue Cross	Total revenue	Charges	Prior to any rate change	Not Applicable	Not Applicable
California	California Health Facilities Commission	Disclosure	Mandatory Disclosure	Not Applicable	Not Applicable	Not Applicable	Annually	Not Applicable	Not Applicable
Colorado	Colorado Hospital Commission	Budget/Rate Review and Approval	Mandatory	All payors except Medicare and Medicaid	Total revenue; rates per admission by revenue center	Rate-based charges	Annually	Volume and intensity	Public Hearing before Commission
Connecticut	Commission on Hospitals and Health Care	Budget/Rate Review and Approval	Mandatory	Charge-based	Total revenue	Charges	Annually	Retroactive volume; unforeseen and material change in expense	Public Hearing before Commission
Maine	Health Facilities Cost Review Board: voluntary budget review organization	Budget/Rate Review	Mandatory Review Voluntary Compliance	Charge-based	Not Applicable	Charges	Annually	Not Applicable	Not Applicable
Maryland	Health Services Cost Review Commission	Budget/Rate Review and Approval	Mandatory	All payors	Total revenue; departmental revenue or guaranteed revenue per case or maximum revenue per case	Rate-based charges	Annually and as necessary	Retroactive possibls for volume and uncontrollsble costs	Public Hearing before Commission
Massachusetts	Massachusetts Rate Setting Commission	Contract/Cost/ Rate Review and Approval	Mandatory	Blue Cross	Cost-based	Routine per diem, Ancillary charges	Annually	Excess costs may be denied	Courts
		Budget/Rate Review and Approval	Mandatory	Charge-based	Total revenue	Charges	Annually	None	Division of Hearing Officers
		Rate Setting	Mandatory	Medicaid	Cost-based	Per diem	Annually	Uncontrollable Costs	Division of Hearing Officers

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Tabls 1 (cont.)

FIFTEEN STATE LEGISLATED HOSPITAL COST CONTAINMENT PROGRAMS

Stata	Responsible Agency	Type of Systam	Voluntary vs. Mandatory	Payors Covered	Revenua Control Method	Unit of Paymant	Frsquency of Raview	Adjustments	Appeals
Minnesota	Dapartment of Health; Minnesota Hospital Associstion	Budget/Rate Review	Mandatory Review Voluntary Compliance	Charge-based including Blue Cross	Total revanue	Chargas	Annually and when requastad during year	None	DOH - Public Hearing before indapandent hearing examinar; MHA - haaring befora appeals panel
New Jersey	Stata Dspartment of Health	Budget/Rate Raview and Approval	Mandatory	Medicaid and Blue Cross	Cost-based	Per diem	Annually	Retroactive for volume, economic factor, pass-through items	Formal appaal befora indapendant hearing officar
New Yonk	Stata Department of Health	Rate Setting	Mandatory	Medicaid and Blue Cross	Cost-based	Per diem	Annually	Retroactive adjust-ment for actual economic factor; volume in downstate Blue Cross	Formal appeal before State hearing officar
Oregon	State Health Planning and Development Agency	Budget/Rate Review	Mandatory Review Voluntary Compliance	Charge-based including Blue Cross	Total revenue	Charges	Annually and when requested during year	Not Applicable	Not Applicable
Rhode Island	State Budget Office; Blue Cross of Rhode Island	Negotiated Budget/Rate Review and Approval	Mandatory	Medicaid and Blue Cross	Total revenue	Charges	Annually	Retroactive volume	Binding arbitration before independent mediation
Virginia	Virginis Health Services Cost Review Commission; voluntary cost review organization	Cost/Charge Review	Mandatory Review Voluntary Compliance	Not Applicable	Not Applicable	Not Applicable	Annual disclosure budgets as necessary	Not Applicable	Not Applicable
Washington	Washington State Hospital Commission	Budget/Rate Review and Approval	Mandatory	All payors --- All payors --- Charge-based	Total revenue; rates per unit of service by revenue center	Rate-based charges	Annually	None --- Volume --- Volume	Formal hearing before commission or independent hearing officer
Wisconsin	State Department of Health; Rate Review Committee	Budget/Rate Review and Approval	Mandatory	All payors except Medicare	Total revenue	Charges	Prior to any rate change at most once a year	None	Hearing before independent appeals board

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Table 2

State Legislative Activity in Hospital Cost Controls

State	Legislation	Legislative Activity Beyond Discussion
Alabama	None	None
Alaska	None	None
Arizona	Budget/Rate Review (1971)	None
Arkansas	None	None
California	Disclosure (1973)	Bills pending for budget/rate review and rate setting
Colorado	Budget/Rate Review and Approval (1977)	None
Connecticut	Budget/Rate Review and Approval (1974)	Bill pending to expand authority to Medicaid
Delaware	None	Bill introduced June 77 referred to committee
Florida	None	Bill introduced April 78
Georgia	None	None
Hawaii	None	None
Idaho	None	None
Illinois	None	Bills pending for rate setting
Indiana	None	None
Iowa	None	None
Kansas	None	Bills defeated, may be reintroduced
Kentucky	None	Bill under study
Louisiana	None	None
Maine	Budget/Rate Review (1978)	None
Maryland	Budget/Rate Review and Approval (1973)	None
Massachusetts	Budget/Rate Review and Approval (1976)	None
Michigan	None	None
Minnesota	Budget/Rate Review (1976)	None
Mississippi	None	Bills defeated
Missouri	None	None
Montana	None	None
Nebraska	None	None
Nevada	None	None
New Hampshire	None	None
New Jersey	Budget/Rate Review and Approval (1971)	Bill pending to expand authority
New Mexico	None	None
New York	Rate Setting (1969)	Bill pending to expand authority
North Carolina	None	None
North Dakota	None	None
Ohio	None	None
Oklahoma	None	None
Oregon	Budget/Rate Review (1977)	None
Pennsylvania	None	Bills defeated
Rhode Island	Negotiated Budget/Rate Review and Approval (1971)	Bill pending to establish commission
South Carolina	None	None
South Dakota	None	Resolution for further study
Tennessee	None	None
Texas	None	None
Utah	None	None
Vermont	None	None
Virginia	Cost/Charge Review (1978)	None
Washington	Budget/Rate Review and Approval (1973)	None
West Virginia	None	Bills defeated
Wisconsin	Budget/Rate Review and Approval (1975)	None
Wyoming	None	None

STATE LAWS ENACTED AS OF APRIL 1978

STATE: Arizona

STATUTE: Arizona Revised Statutes: Title 36, Chapter 4, Article 3; Title 36, Chapter 1, Article 1.1

DATE: 1971 and Subsequent Amendments

PURPOSE: Review of rates and charges, prescribing uniform accounting, and public disclosure of financial and statistical data for health care institutions

RESPONSIBLE AGENCY: Local HSA, State Department of Health Services Regulations governing reporting requirements and procedures for hospital rate review are issued under the authority of the Department of Health Services. Review and comment on proposed charges are performed by both the local Health Systems Agency and the State Department of Health Services.

The HSA holds a public hearing after which it decides whether or not to recommend approval. The Department of Health Services simultaneously conducts its own review. The Department considers but is not bound by the recommendation of the HSA. After its own review the Department issues a statement as to whether the proposed rates are justified, and if not, what if any level of increase would be justified.

FACILITIES COVERED: Mandatory participation but voluntary compliance by all nonfederal hospitals.

PAYORS COVERED: Charge-based payors (includes Blue Cross)

CURRENT PROGRAM:

The Department has implemented uniform accounting and an annual reporting system and will be publishing annual financial and statistical public disclosure reports. Hospitals are required to file on prescribed forms a notice of any proposed change in charges with both the local HSA and the Department of Health Services at least 60 days prior to the implementation date. In addition to a list of charges the facility must supply cost and statistical data on its past, current, and prospective fiscal years. Analysis focuses on the changes from historical costs to the proposed budget year. Primary factors considered are inflation (separately considering salaries, supplies, and utilities), volume changes, and the total financial needs of the institution. Interhospital comparison may be done for a particular cost center or area. Groupings vary from case to case. The finding as to whether the proposed charges are justified is based on their appropriateness in relation to the above analysis of costs. The local HSA must conduct a public hearing within 30 days and issue its findings within 45 days from the date of filing. The Department of Health Services must issue its findings within 60 days of the date of filing. There is no fiscal risk or incentive for hospitals since compliance is voluntary. There are no retroactive adjustments.

HEARINGS/APPEALS:

There is no appeals mechanism since compliance is voluntary. A public hearing may be conducted by the State in order to receive and review additional relevant information and to resolve differences between the

findings of the two review agencies. The hearings panel for the State is the Health Economics Committee of the Statewide Health Coordinating Council. While compliance is voluntary, emphasis is placed on public disclosure of unfavorable findings.

DEVELOPMENTAL ACTIVITIES:

Consideration is being given to changing the basis of the review period from the planned date of increase in charges to an annual review of the budgeted years.

PENDING LEGISLATION: None

CONTACT FOR ADDITIONAL INFORMATION:

Chief, Bureau of Health Economics
Division of Health Resources
Arizona Department of Health Services
1740 West Adams Street
Phoenix, Arizona 85007

STATE: California

STATUTE: Chapter 1242, Statutes of 1971, California Health Facilities Disclosure Act, as amended

DATE: 1973

PURPOSE: To encourage economy and efficiency by enabling purchasers of care to make informed decisions, and to allow for comparisons of the performance of particular health facilities through public disclosure of health facility financial and statistical data.

RESPONSIBLE AGENCY: California Health Facilities Commission

The Commission consists of 15 members apointed by the Governor. Seven of the members represent the health care industry and eight represent the public. The Commission has authority to require public disclosure of financial and statistical information by California health care facilities. While legislation has in the past been introduced to expand the role of the Commission, to date it has no authority for rate review or approval.

FACILITIES COVERED: Mandatory accounting and reporting by all hospitals, skilled nursing facilities, and intermediate care facilities.

CURRENT PROGRAM:

The Commission has established uniform accounting and reporting systems which must be used by hospitals, skilled nursing facilities, and intermediate care facilities in reporting their financial data.

PENDING LEGISLATION: There are currently bills before the legislature which would give the Commission budget and rate review authority.

CONTACT FOR ADDITIONAL INFORMATION:

Executive Director
California Health Facilities Commission
555 Capitol Mall, Room 525
Sacramento, California 95814

STATE: Colorado

STATUTE: Title 12, Colorado Revised Statutes 1973 as Amended

DATE: 1977

PURPOSE: To restrain the rising cost of hospital care by a system of prospective budget review and approval of hospital budgets, costs and charges while assuring that all hospital charges are reasonably related to hospital costs.

RESPONSIBLE AGENCY: Colorado Hospital Commission

The Colorado Hospital Commission consists of three members appointed by the Governor with the consent of the Senate to staggered 6-year terms. No member may have any affiliation with or financial interest in any organization subject to regulation by the Commission. It is an independent Commission but operates within the Department of Regulatory Agencies. The Commission has the authority to establish rates and issue rules and regulations as necessary for the rate setting system. The Commission appoints a full time executive officer and the executive director of the Department of Regulatory Agencies appoints the remainder of the staff with the consent of the Commission.

The Commission is assisted in its mission by a 12 member Health Care Policy Advisory Board whose role is to provide advice and assistance as requested by the Commission. The members of this board are appointed by the Governor to represent consumers, providers, and other interested parties.

FACILITIES COVERED: Mandatory participation and compliance by all nonfederal hospitals.

PAYORS COVERED: All payors except Medicaid and Medicare

CURRENT PROGRAM:

In order to begin setting rules by April 1, 1978, as required by statute, the Commission has adopted an interim rate review system. Hospitals are annually required to submit data for the past, current, and prospective budget years 90 days prior to the beginning of their fiscal years using a uniform accounting and reporting system.

Budget analysis is based on two levels. The first level consists of review against two screens: 1) percent increase per equivalent inpatient admission from the current to prospective year; 2) percent increase per equivalent inpatient admission from the past to the prospective year.

The cutoff level for passing the screen will vary from year to year as a function of the rate of inflation and other factors. If a hospital passes both primary screens there is no further review. The hospital's budget is then used to establish rates which, for an equivalent inpatient admission volume, will generate sufficient revenue to meet the hospital's fiscal needs.

If a hospital fails a primary screen, the facility is required to submit additional data for a detailed review. This second level of review involves peer grouping and the application of utilization and labor productivity standards. If after the review the staff is satisfied that the request is justified, the rates are reviewed and approved by the Commissioners. If the staff does not find the rates justified, the staff enters into detailed negotiations with the facility. Staff then presents its findings at a conference with the Commissioners. If the facility does not agree with the Commissioners' decision, it may appeal.

There are no retroactive adjustments except for extraordinary occurrences beyond the control of the hospital, but there are provisions for year end adjustments for variance from projected volumes and intensity.

HEARINGS/APPEALS:

If a facility disagrees with staff findings it may request a formal hearing before the Commission. If a facility does not accept the decision of the Commission, its next appeal is the courts.

DEVELOPMENTAL ACTIVITIES:

Further development and refinement of the rate review system.

PENDING LEGISLATION: None

CONTACT FOR ADDITIONAL INFORMATION:

Chairperson
Colorado Hospital Commission
1390 Logan Street, Suite 400
Denver, Colorado 80203

STATE: Connecticut

STATUTE: Public Act No. 73-117 Connecticut GSA 19-73a through 73q as amended

DATE: July 1974

PURPOSE: Create a Commission to improve efficiency, lower health care costs, coordinate use of facilities and services and expand availability of health care throughout the State.

RESPONSIBLE AGENCY: Commission on Hospitals and Health Care

The Commission on Hospitals and Health Care consists of 17 members: three ex-officio (Commissioners of Health, Mental Health and Insurance), 14 appointed to represent the public and the industry (12 appointed by the Governor, 1 appointed by the Speaker of the House and 1 appointed by the President pro tempare of the Senate). The Commission has direct authority to review and approve hospital budgets.

The Commission appoints a full time executive director who is responsible for the day to day operations of the Commission.

FACILITIES COVERED: Mandatory participation and compliance by all nongovernmental hospitals.

PAYORS COVERED: Charge-based payors

CURRENT PROGRAM:

Hospitals are required to submit by July 1, detailed cost and statistical data for the past, current, and prospective year utilizing a uniform reporting system. The budget year reviewed begins October 1.

The review process considers the overall financial requirements of the hospital to establish an approved total revenue figure. The process begins by comparing the base (current) year projected actual budget to the amount approved for that year.

Base year costs are then screened by comparing, by group, three clusters of costs: general services, routine, and ancillary. Groups are established based on the size and scope of services. If a hospital's cluster costs exceed 110 percent of the median the individual cost centers within that cluster are also screened. Within each cost center any amount in excess of 110 percent of median costs for the group are challenged. Base year costs are also screened for changes from budgeted volume.

After the above adjustments, if any, the reasonable base year costs are adjusted for inflation, volume, and nonvolume changes to establish a reasonable prospective operating budget. Nonvolume changes consist primarily of new or expanded services.

In addition to the operating expenses budget the Commission also considers the Capital Expenditure Budget, required working capital, contractual allowances and payor mix and other financial requirements in establishing the total patient revenue needs for the hospital.

This total revenue required is then translated by the facility into a schedule of charges.

The facility is at risk for revenue in excess of the approved level, after adjusting for volume. Any such excess is applied to next year's financial requirements.

The only retroactive adjustment is for changes from budgeted volume. However, the facility may request an adjustment during the year to meet unforeseen and material change in expenses.

HEARINGS/APPEALS:

The facility has the opportunity to informally review its requested budget with the Commission staff before the staff makes its recommendations to the full Commission. If the hospital disagrees with the initial Commission decision, it may request a public hearing of record before a panel of three Commissioners. Having heard the facility's position the panel makes a formal report and recommendation to the full Commission. The facility has the opportunity to comment on the report before the Commission makes a decision.

If the hospital disagrees with the final decision of the full Commission it may appeal to the courts.

DEVELOPMENTAL ACTIVITIES:

Under HCFA contract No. 600-76-0172 the Commission is developing new methodologies to be incorporated into the budget review system which include: further refinement of the inflation factor; more sophisticated volume adjustments for fixed and variable costs and improved grouping and productivity screens.

PENDING LEGISLATION:

Legislation has been passed by the legislature and is awaiting the governor's signature which would require the State Medicaid program, subject to Federal waivers, to reimburse using the Commission rate.

CONTACT FOR ADDITIONAL INFORMATION:

Executive Director
Commission on Hospitals and Health Care
340 Capitol Avenue
Hartford, Connecticut 06115

STATE: Maine

STATUTE: Sec. 1.22 MRSA Chapter 105, Health Facilities Information Disclosure Act

DATE: April 1978

PURPOSE: To establish uniform systems of reporting health care information and to provide for the review of and comment on the proposed budgets of any hospital.

RESPONSIBLE AGENCY: Health Facilities Cost Review Board or approved voluntary budget review organization.

The Health Facilities Cost Review Board will consist of 10 members, 8 of which are appointed by the Governor. Five are consumer representatives and three are industry or provider representatives. In addition, the Commissioner of Human Services or his designee will serve as an ex officio voting member and the Superintendent of Insurance or his designee will serve as an ex officio nonvoting member. The Board may designate a voluntary budget review organization to carry out the provisions of this act. The law provides for an exemption to the voluntary budget review organization from State anti-trust statutes.

FACILITIES COVERED: Mandatory participation but voluntary compliance by all nonfederal hospitals.

CURRENT PROGRAM:

This law was enacted in April 1978. No specific procedures have been developed. The law does specify that the board or an approved voluntary budget review organization will require each hospital to annually file

uniform financial and scope of service information. In addition each health facility will file with an independent data organization a complete Uniform Hospital Discharge Data Set on each person discharged from the facility. Hospitals will also file budgets for their next fiscal year. A review of hospital budgets will be conducted to determine whether rates and charges in the aggregate are reasonably just and reasonably related to financial requirements, and that these prospective rates and charges are allocated equitably among all purchasers of health services without undue discrimination, except as required by Federal and State statutes or regulations.

STATE: Maryland

STATUTE: Article 43, Section 568H Through 568Y Annotated Code of Maryland

DATE: July 1973, with subsequent amendments

PURPOSE: To make public the financial positions of hospitals and related institutions and to assure all purchasers of hospital services that costs are reasonably related to services offered and to establish equitable rates for all purchasers of services.

RESPONSIBLE AGENCY: Health Services Cost Review Commission

The Health Services Cost Review Commission is a seven member independent commission appointed by the Governor. A majority of the Commission must not have any connection with the management or policy development of any hospital or related institutions.

Prospective rates are developed by a full time professional staff operating under regulations issued by the Commission. In addition to the promulgation of reimbursement rates, the Commission has the authority to hold public hearings, conduct investigations and require the submission of data relevant to the cost of hospital services.

FACILITIES COVERED: Mandatory participation and compliance by all nonfederal hospitals.

PAYORS COVERED: All purchasers of hospital services (Medicare and Medicaid on an experimental basis).

CURRENT PROGRAM:

The Maryland rate setting system entails two levels of budget review, the first level is applied to all hospitals annually; the second more detailed analysis is conducted at the request of the facility or on a selective basis by the Commission.

All hospitals are annually required to submit data on base and budgeted years 90 days after the end of the hospital's fiscal year, using a uniform accounting and reporting system. At the first level of review the changes in operating costs from base to budget year are analyzed considering: changes in volume, inflation factors, changes in payor and case mixes, uncontrollable cost items (e.g., malpractice). An adjustment is also made to a hospital's Capital Facilities Allowance to adjust for changes in price levels (N.B. the Capital Facilities Allowance is used in place of historical cost depreciation to allow hospitals payment for equipment usage at a level which allows replacement at current market prices and for a downpayment for buildings based on 20 percent of current market prices for those hospitals which are effectively utilized). The results of the above review are used to develop a list of rates which will meet the hospital's reasonable financial needs. If the facility accepts the list of rates this is usually the end of the review. If the facility maintains that its needs are greater than the Commission has recognized it can request a detailed budget review.

The second level of analysis is individually structured to the facility under review. It may be initiated at the request of the hospital, or by a decision of the Commission to more closely examine a particular hospital. At this level the analysis is on a more detailed level and would entail a review of relevant cost centers. Standards of measure used would vary by cost center.

The results of this detailed budget review are used to establish a revised list of rates which could be greater or lesser than those which resulted from the first level of review.

Retroactive adjustments are possible because of changes in volume and/or uncontrollable costs (e.g., malpractice).

HEARINGS/APPEALS:

If the facility is not satisfied with its initial rates it may request a detailed budget review. If dissatisfied with the outcome of the detailed budget review, a hospital may request a hearing before the Commissioners. If dissatisfied with the decision of the Commissioners recourse is to the courts.

DEVELOPMENTAL ACTIVITIES:

Under HCFA contract No. 600-76-0140 the Commission is: refining methodology to adjust for case mix, reviewing the economic impact of State hospital regulations, and establishing a statewide policy to deal with charity

care. The Commission is also experimenting with payment systems based on a guaranteed payment per case and a maximum payment per case.

PENDING LEGISLATION:

Legislation is currently pending which would shift the financing of the Commission to a direct tax on hospitals.

CONTACT FOR ADDITIONAL INFORMATION:

Executive Director
Health Services Cost Review Commission
201 West Preston Street
First Floor
Baltimore, Maryland 21201

STATE: Massachusetts

STATUTE: Blue Cross: MLG c. 176A, s. 5

Public Assistance (including Medicaid): MGL c. 6A, ss. 31-36

Charge Payors: Chapter 409 of the Acts of 1976

DATE: 1976

PURPOSE: To establish fair, reasonable, and adequate rates and to reorganize in an equitable and feasible manner the health care delivery system of Massachusetts.

RESPONSIBLE AGENCY: Massachusetts Rate Setting Commission

The Massachusetts Rate Setting Commission consists of three commissioners appointed by the Governor. The work of the Commission is performed by a full time professional staff. The staff is supported by an Advisory Council consisting of representatives of both the public and the health care industry. In addition, activities related to hospital charge and budget reviews are overseen by the Hospital Policy Review Board. This group's authority is limited to review and comment on proposed rules and regulations.

FACILITIES COVERED: There is mandatory participation and compliance by all nonfederal hospitals.

PAYORS COVERED: Charge-based payors. Rates are set separately for Blue Cross and for Medicaid.

CURRENT PROGRAM:

The Massachusetts Commission is unique in that it utilizes different methodologies for determining the reimbursement rate for different payors.

A) Blue Cross

The Commission's involvement with Blue Cross rates consists of review and approval of proposed contracts between Blue Cross and hospitals, and rates developed under those contracts.

Retrospectively, the Commission staff reviews and audits facilities' cost reports. A uniform reporting system is utilized for Blue Cross and Medicaid, though some variation in the method of reporting is permitted. In addition to the audit of rate year costs, those costs are reviewed in comparison to the prior year to analyze incremental cost increases, volume changes, and items beyond management control (e.g., FICA, malpractice) unique to each facility. Any amount in excess of costs so determined may be denied the facility. The facility does, under the Blue Cross contract, have the opportunity to justify any unusual expenses. The Commission establishes a per diem for routine costs and charges for ancillary services.

B) Medicaid

Hospitals are required to submit annually historical costs using a uniform reporting system. Base year costs are indexed forward to the budgeted year using a Commission generated inflation factor. Budgeted costs in excess of the indexed costs are disallowed, with the exception

of items beyond the control of management (e.g., FICA) and new costs associated with major capital expenditures approved through the certificate of need program. The approved projected cost is used to generate an all inclusive per diem, subject to minimum occupancy levels which vary by service. In addition, bed and board costs are subject to Medicare routine per diem limitations. No interhospital comparisons are conducted. While there are no retroactive adjustments, administrative adjustments for uncontrollable costs are permitted during the year. The facility is at risk for any overexpenditure.

C) Charge Payors

Hospitals are required annually to submit past, current, and prospective costs using a uniform reporting format. Base year costs are indexed forward and adjusted for changes in volume and costs beyond management control. The resulting reasonable cost base is used to establish allowable charges, subject to a maximum cost to charge ratio of 95 percent. There are no retroactive adjustments. The facility is at risk for any overexpenditure but is also the beneficiary of any excess profits.

HEARINGS/APPEALS:

Facilities have the right to appeal non-Blue Cross decisions of the Commission under the State's administrative procedures act to the Division of Hearing Officers. If dissatisfied with the outcome at that level they have recourse to the courts. Blue Cross decisions can be appealed directly to the courts.

DEVELOPMENTAL ACTIVITIES:

Under Federal contract HCFA No. 600-76-0174 the Commission is developing a uniform data base and cost reporting system, more precise cost definitions, refined inflation factors, methods of volume and case mix adjustments, cost evaluation methods using both interhospital and regression analysis, and a system of incentives and disincentives. Interhospital comparisons will be performed on a departmental basis. Under the existing legislation governing charge payors, the Commission must develop for FY 1979 reviews a definition of the "reasonable financial requirements" of hospitals; and must develop for FY 1980 reviews a grouping methodology for purposes of permitting inter-institutional comparisons.

PENDING LEGISLATION: None

CONTACT FOR ADDITIONAL INFORMATION:

Chairperson
The Commonwealth of Massachusetts
Rate Setting Commission
One Ashburton Place
Boston, Massachusetts 02108

STATE: Minnesota

STATUTE: Minnesota Statutes Section 144.695 through 144.703

DATE: 1976

PURPOSE: To assure all purchasers of hospital services that the total costs of a hospital are reasonably related to the total services offered, that the hospital's aggregate revenues as expressed by rates are reasonably related to the hospital's aggregate costs and that rates are set equitably among payors.

RESPONSIBLE AGENCY: Department of Health, Other Approved Nonprofit Agency The Commissioner of Health has the responsibility to establish rules and regulations governing the Department's review of hospital budgets. The authority for review and comment on the reasonableness of the hospital rates rests with the Commissioner. In addition, the Commissioner may certify a program of budget review and comment operated by a nonprofit corporation which hospitals may participate with in place of State review. The Minnesota Hospital Association has been so designated and all but one hospital submits its rates for review by the Association.

FACILITIES COVERED: Mandatory participation but voluntary compliance by all nonfederal hospitals.

PAYORS COVERED: Charge-based payors (includes Blue Cross).

CURRENT PROGRAM:

Hospitals are required to submit cost and statistical data for past, current, and prospective budget years before the beginning of the fiscal year and at least 60 days before any rate changes go into effect. There is no uniform accounting and reporting system.

Groupings are established through a cluster analysis which considers the following: geographic locations, service index, percent of surgery to total admissions, percents of Medicaid and Medicare to total admissions, and level of teaching activity. Within groups hospital costs are analyzed for variance from the average cost per adjusted admission. A variance must be justified by the hospital.

Cost increases are reviewed by department and by natural cost groupings within the department.

Depreciation is indexed forward from historical cost to reflect the impact of inflation and must be funded. Consideration is given to the need for replacement beds.

In addition to analysis of the operating budget, the capital expenditure budget and projected working capital needs are reviewed to establish the overall reasonable financial needs of the facility. There are no retroactive adjustments but a facility may request an interim adjustment at any time during the year.

There are no direct incentives or risks, however, through contract Blue Cross reimbursement is limited to approved rates. A compliance review is performed. Revenues in excess of financial needs must be applied against next year's needs. Justified losses may also be offset in next year's revenue.

HEARINGS/APPEALS:

The system of hearings and appeals is different for hospitals reviewed by the hospital association and the hospital(s) reviewed by the State.

Minnesota Hospital Association: After informal discussions are held between staff and the facilities, a seven member review panel (four consumer members, three provider members) examines and rules on all issues. If the facility is dissatisfied with the review panel it may request another hearing before an appeals panel.

Department of Health: If points of difference cannot be resolved by informal discussions between staff and the facility, a public hearing is held, presided over by an independent hearing examiner. The findings of the hearing examiner are reviewed by the Commissioner of Health. The final decision is made by the Commissioner with the advice and consent of the attorney general.

DEVELOPMENTAL ACTIVITIES:

Work is currently being done to refine grouping techniques and the methodology for developing the inflation factor. A cost estimating model is being considered in lieu of interhospital comparisons.

PENDING LEGISLATION: None

CONTACT FOR ADDITIONAL INFORMATION:

Director of Rate Review
Minnesota Department of Health
717 Delaware Street, SE.
Minneapolis, Minnesota 55440

Director, Rate Review
Minnesota Hospital Association
2333 University Avenue, SE.
Minneapolis, Minnesota 55414

STATE: New Jersey

STATUTE: New Jersey Health Care Facilities Planning Act

Chapters 136 and 138 Laws of New Jersey 1971

DATE: 1971

PURPOSE: To assure high quality hospital and related health care services, efficiently provided and properly utilized at a reasonable cost.

RESPONSIBLE AGENCY: Departments of Health and Insurance

Prospective rates are developed by the staff of the Department of Health under regulations promulgated by the Health Care Administration Board, and issued under the joint authority of the Commissioners of Health and Insurance. The Health Care Administration Board consists of the Commissioners of Health and Insurance, ex-officio, plus 11 additional members apointed by the Governor and confirmed by the State Senate, representing both the public and the hospital industry.

FACILITIES COVERED: Mandatory participation and compliance by all nongovernmental hospitals.

PAYORS COVERED: Blue Cross, Medicaid, other State governmental payors.

CURRENT PROGRAM:

Hospitals are required to annually submit an operating budget prior to the proposed budget year using a uniform accounting and statistical

system. This data contains information on both the base (most recent) year and the budget year.

Cost analysis consists of a) a global comparison of the submitted base year budget to the facility's approved amount for that year, with adjustments to the base for overexpenditures; b) an interhospital cost comparison of individual cost centers and clusters of cost centers to determine reasonableness of base year costs. Reasonableness is determined by the use of screens. For interhospital comparisons groupings (size, teaching, geographic area) vary according to the cost center; c) after determination of a reasonable budget base adjustments are made for inflation, volume changes, legally mandated changes and requested new management projects to determine an approved prospective budget.

Expenses in certain cost centers: malpractice, utilities, depreciation, and legally mandated fringe benefits are pass-through items.

The global approved budget is divided by the budgeted patient days to determine the per diem for the budget year. The facility is at risk for all overexpenditures with the approved per diem serving as a ceiling for the obligation of Blue Cross and Medicaid. However, retrospective adjustments are made for changes in volume, actual economic factor experience, and the pass-through items mentioned above.

HEARINGS/APPEALS:

After the rate is set the facility has the right to an informal meeting with the staff of the Department of Health to justify the addition of

disallowed costs. Both the facility and third party payors have the right to a formal appeal before an independent hearing officer under the State's administrative procedures act. Further appeal from the hearing officer level may be made to State court.

DEVELOPMENTAL ACTIVITIES:

Under HCFA Contract No. 600-77-0022, the New Jersey State Department of Health is developing a system of prospective reimbursement for hospitals based on their patient case mix. This endeavor begins with the classification of inpatients into "Diagnosis Related Groups" (DRGs). These DRGs furnish the foundation for a common denominator previously lacking to hospital regulatory agencies, thereby facilitating the development of quasi-public utilities model for hospital rate-setting.

Since January 1, 1979, the Department of Health has been receiving medical discharge abstracts from all 118 acute care hospitals in the State. Selected variables from these discharges are used to categorize cases into 383 medically meaningful and statistically stable DRGs by means of a patient classification scheme referred to as "AUTOGRP."

A second phase of the project has involved the allocation of patient care costs to DRGs for 18 voluntarily participating hospitals. In order to apply costs to the DRGs, functionally grouped cost data (as obtained from New Jersey's present peer grouped based rate setting method, Standard Hospital Accounting and Rate Evaluation System - SHARE)

are allocated to patients based on various statistics, e.g., for ancillary services, the ratio of cost to charges is used; for nursing services, weighted statistics reflecting relative intensities of nursing needs and services are being developed; for patient care general services such as dietary services, alternate statistics for apportionment are under development. In early 1978, certain participating hospitals will have the option of selecting their rates set through SHARE, or a rate based on case mix for patient care costs and a peer-group based method for institutional costs. In order to test this case-mix model throughout the State, the project is currently implementing steps to obtain the necessary statistics, such as charge data through the uniform billing reporting regulation.

PENDING LEGISLATION:

A bill is currently pending before the State legislature to expand the State's rate setting authority to cover all nonfederal payors.

CONTACT FOR ADDITIONAL INFORMATION:

Assistant Commissioner
Division of Health Planning and Resource Development
New Jersey State Department of Health
John Fitch Plaza
P.O. 1540
Trenton, New Jersey 08625

STATE: New York

STATUTE: Public Health Law Sections 2800 through 2807

DATE: 1969 and amendments

PURPOSE: To promote hospital and health-related services of the highest quality, effiently provided and properly utilized at a reasonable cost.

RESPONSIBLE AGENCY: Department of Health

The Commissioner of the Department of Health has the responsibility to certify that proposed rates are reasonably related to the costs of delivering efficient health care services. Rates for Medicaid are certified to the Director of the Budget, rates for Blue Cross are certified to the Superintendent of Insurance and rates for Workman's Compensation are certified to the chairperson of the Workman's Compensation Board. Rates for Medicaid are developed by the staff of the Department of Health under regulations approved by the State Hospital Review and Planning Council. Blue Cross rates are developed separately by Blue Cross plans (upstate - 6 plans and downstate) utilizing procedures, approved by the Department of Health, which are "not inconsistent" with the regulations passed by the Council. The Department of Health has the responsibility to review the rates developed by the Blue Cross plans prior to certifying them to the Superintendent of Insurance.

FACILITIES COVERED: Mandatory participation and compliance by all nonfederal hospitals.

PAYORS COVERED: Medicaid, Blue Cross, Workman's Compensation, and No-Fault Insurance

CURRENT PROGRAM:

There are in effect three separate though similar rate setting systems in New York. The Medicaid system is administered by the Department of Health for all hospitals in the State. Blue Cross rates are set by one of two basic systems: the downstate system (New York City metropolitan area) or the upstate system (remainder of the State). Note- There are six separate upstate plans which vary slightly in their systems.

For all three systems hospitals are required to file with the State and respective Blue Cross plan, a uniform cost report within 120 days of the close of the fiscal year. They must use the Uniform Financial Reporting System (UFR. USR) which includes both financial and statistical data. In addition they must file supplemental data for both Blue Cross and Medicaid to account for differences in coverages.

Medicaid System: Base year costs are analyzed through interhospital group comparisons. Groupings are determined by an algorithm which weighs such factors as: number of beds, number of teaching programs, payor mix, services offered, surgical admissions as percentage of total. Routine costs are screened against an adjusted group average per diem and ancillary costs are screened against an adjusted group average per discharge.

An Additional adjustment is made for excessive length of stay equal to per diem routine costs times the number of excess days.

Base year costs minus any adjustment and exclusive of capital costs and historical cost depreciation (which are pass-through costs) are indexed forward to the prospective budget year. These indexed costs plus capital and depreciation costs are then divided by patient days (adjusted for minimum occupancy levels by service) to establish a per diem.

Blue Cross Systems: There are two major differences between the Medicaid system and the two Blue Cross systems: groupings and screening of base year costs. The upstate system groups hospitals by bed size within Blue Cross plans. Overall base year operating costs are then screened against the average cost per adjusted discharge (adjusted for a standard length of stay). The downstate system groups hospitals by use of a service index which weighs type and intensity of services offered, and level of teaching activity.

Except for downstate Blue Cross the system does not adjust for changes in volume or directly for additions or expansion of services. A hospital can however, appeal its rate on the basis of expanded services. The downstate Blue Cross system does provide for an audit adjustment for volume.

The facility is at risk for any overexpenditure and can keep any profit resulting from underexpenditures. Each system allows for a retroactive adjustment for actual variance in the economic factors.

HEARINGS/APPEALS:

Hospitals have 120 days to file an appeal with the State, specifying why they believe their rate to be inadequate. Staff then reviews the hospital's submission and makes a recommendation to the Commissioner of Health. If the facility is dissatisfied it may request a formal appeal before a State Hearing Officer. If dissatisfied with the results of the formal appeal recourse is to the courts.

DEVELOPMENTAL ACTIVITIES:

Under HCFA grant No. 18-P-90707/2-01 the New York State Office of Health Systems Management will develop and implement the necessary statistical and financial reporting systems to support a model health care financing data system. All hospitals in the State of New York will be required to adopt by January 1, 1979, the HCFA uniform reporting system, a uniform billing set for all patients, and a uniform patient discharge abstract set for all patients that is linked to the uniform billing information. These source documents will be collected, computerized, and merged into master data files in order to establish a uniform, comprehensive, and centralized source for hospital statistical, medical, and financial information. Output reports will be developed from these files for purposes of effective management at the institutional level and for

planning and rate setting needs at the statewide level. The project also involves developmental efforts for measuring case mix complexity and for designing reimbursement methodologies based on per admission payment adjusted for hospital caseload complexities.

PENDING LEGISLATION:

Legislation is currently pending which would add the authority to control charges to the self-pay population.

CONTACT FOR ADDITIONAL INFORMATION:

Director
Office of Health Systems Management
Tower Building
Empire State Plaza
Albany, New York 12237

STATE: Oregon

STATUTE: ORS Chapter 442, Sections 400 through 450

DATE: July 1977

PURPOSE: To achieve equal access to quality health care at a reasonable cost.

RESPONSIBLE AGENCY: State Health Planning and Development Agency

The Oregon State Health Planning and Development Agency is responsible for the review of and comment on existing and proposed hospital rates. The agency has no enforcement powers, but it is required to make public rates which it finds to be unreasonable. The Director of the agency has the authority to review the rates and determine the reasonableness of the rates. The Director is appointed by and serves at the pleasure of the Governor.

The Oregon Statewide Health Coordinating Council serves as an advisory council to the agency on general policymaking issues. It is composed of 31 voting members appointed by the Governor such that at least 51 percent, but not more than 60 percent, are consumers.

FACILITIES COVERED: Mandatory participation but voluntary compliance by all nonfederal hospitals.

PAYORS COVERED: Charge-based payors (includes Blue Cross)

CURRENT PROGRAM:

The rate review system is now in place. While specific review criteria have not yet been established, the general methodology is as follows:

Hospitals will submit budget data for the prospective year 30 days prior to the beginning of their fiscal year. Operating and fiscal data will be reported monthly via American Hospital Association's Hospital Administrative Services (HAS) system. There are no standard accounting forms, but the monthly reporting is on the standard HAS form for computer input. This information will be submitted to both the State agency and a local peer review council.

Both the State staff and the local peer review council will review the budget (capital and operating) and HAS monthly reports, on both a global and cost center basis to determine the reasonableness of the budgeted amount considering such factors as inflation and volume charges, and on the rates being charged.

Both groups make recommendations to the agency director as to the reasonableness of the budget and charges. A nine member panel composed of three providers, three representatives of the State and three representatives of major purchasers of health care services is established as a mediation panel in the event of conflicting recommendations. The nine member panel reviews both conflicting reports and makes a recommendation to the agency director.

There is no provision for retroactive adjustments. However, a facility may give notice of a change of rates at any time during the year, subject to an advance notice of 30 days. The State agency has no authority to set, reverse, deny or approve rates - but may only comment on their reasonableness.

HEARINGS/APPEALS:

Since compliance is voluntary, there is no mechanism for appeal.

DEVELOPMENTAL ACTIVITIES: None

PENDING LEGISLATION: None

CONTACT FOR ADDITIONAL INFORMATION:

Manager
Health Economics and Resource Development Section
State Health Planning and Development Agency
2111 Front Street, N.E., Suite 108
Salem, Oregon 97310

STATE: Rhode Island

STATUTE: Chapter 208, Title 27 of the General Laws

DATE: July 1971

PURPOSE: To make the State, hospitals, and hospital service corporations parties to budget negotiations held for the purpose of determining prospective payment rates for hospital costs by the State and such corporations.

RESPONSIBLE AGENCIES: Blue Cross, State Budget Office

Negotiations are conducted between the staff of Blue Cross, the State Budget Office, and the Hospital Association of Rhode Island to set a Maxicap, the maximum percentage increase in total hospital expenditures allowed in the State during the coming year. Subsequently, hospital budget negotiations are conducted between the staffs of Blue Cross and the State Budget Office (jointly referred to as the Third Parties) and the hospitals. The State has not issued specific regulations defining the rate review process. But rather, the process is established in a contractual agreement between the hospitals, Blue Cross, and the State Budget Office.

FACILITIES COVERED: Mandatory participation and compliance of all nonfederal hospitals.

PAYORS COVERED: Blue Cross, Medicaid

CURRENT PROGRAM:

A Maxicap is set annually by negotiation. Hospitals annually submit cost data on their current and prospective budget years using a uniform reporting system. The budget review process focuses on the incremental changes from current to prospective years. These changes are reviewed on both a global and cost center level. Hospitals are grouped but interhospital comparisons are limited. In assessing the increment from the base year, the Third Parties consider inflation, volume changes, and the provision of new and expanded services. In determining the appropriateness of new or expanded services a statewide medical program review and priority process is used.

After total operating expenses have been negotiated, the hospital uses them to establish a schedule of charges. This schedule is reviewed by Blue Cross and the State Budget Office for accuracy of revenue calculations. The schedule of charges is then used to establish separate rates for Blue Cross and Medicaid by adjusting for costing and benefit differences.

HEARINGS/APPEALS:

If the third parties and a hospital cannot reach agreement, negotiations end and a two phase review process begins. First both sides we brought together for formal mediation. This process differs from normal negotiations in that it involves both members of the hospital's governing board and officials of third parties. Second, if mediation does not result in agreement, issues unresolved when negotiations ended

go before an independent arbitrator for binding arbitration. The arbitrator must then choose one of the two positions and is not free to consider any modifications of positions which might have occurred during mediation.

DEVELOPMENTAL ACTIVITIES:

The program has been operational since fiscal year 1975. Blue Cross and the State are in the process of evaluating the program for the 3 years (fiscal years 1975, 1976, and 1977) that Medicare participated.

PENDING LEGISLATION:

There is currently a bill before the State legislature which would establish a Rate Review Commission.

CONTACT FOR ADDITIONAL INFORMATION:

Director of Reimbursement
Blue Cross of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901

Budget Program and Management Specialist
State Budget Office
Room 110
State House
Providence, Rhode Island 02903

STATE: Virginia

STATUTE: Code of Virginia, Title 9, Chapter 24

DATE: April 1978

PURPOSE: To establish a uniform system of financial reporting, to publish and disseminate information relating to health care institutions' costs and charges, and to initiate reviews or investigate as necessary to assure all purchasers of health care services that the aggregate charges are reasonably related to reasonable costs, and that charges are equitable.

RESPONSIBLE AGENCY: Virginia Health Services Cost Review Commission or designated voluntary cost review organization

FACILITIES COVERED: Mandatory participation but voluntary compliance by all nonfederal hospitals.

CURRENT PROGRAM:

This law was enacted in April 1978. No specific procedures have been developed. The law does specify that the Commission may approve voluntary reporting and cost review procedures and a hospital may submit its financial reports to and be subject to a review of its costs and charges by an approved voluntary cost review organization in lieu of filing with the Commission. The Commission will establish a uniform system of financial reporting within two and one-half years from the date of formation of the

Commission. Hospitals are required to file annually a certified balance sheet and statement of income and expense and such other reports of the costs incurred in rendering services as the Commission may prescribe. In addition, the Commission will obtain annually from each hospital a current charge schedule and may publicly comment on any increase or decrease which it determines to be excessive or inadequate.

STATE: Washington

STATUTE: RCW Title 70, Chapter 39 (Chapter 5 Laws of 1973, First Ex. Sess.)

DATE: March 1973

PURPOSE: To establish a hospital commission with authority over financial disclosure, budget, prospective rate review and other related matters, which will assure all purchasers of hospital health care services that total hospital costs are reasonably related to total services, that hospital rates are reasonably related to aggregate costs, and that such rates are set equitably among all purchasers of these services without undue discrimination.

RESPONSIBLE AGENCY: Washington State Hospital Commission

The Washington State Hospital Commission is a five member independent commission, appointed by the Governor and confirmed by the Senate, from the categories of: consumer, labor, business, and hospitals. No more than two members may have a fiduciary duty to a health facility or agency or have a financial interest in the rendering of health services. Rules and regulations for rate setting are issued under the direct authority of the Commission. The Commission is assisted in its activities by an 11 member technical advisory committee also appointed by the Governor. The advisory committee's duty is to consult and make recommendations to the Commission on matters of policy, rules, and regulations, as requested by the Commission.

The rate review is performed by a full time professional staff, headed by an executive director appointed by the Commission. Rates are issued under the authority of and after review by a full commission.

FACILITIES COVERED: Mandatory participation and compliance by all nonfederal hospitals.

PAYORS COVERED: All purchasers of hospital services (Medicare, Medicaid, and Blue Cross on an experimental basis)

CURRENT PROGRAM:

Each hospital is required to submit at least 60 days prior to the beginning of its fiscal year, detailed information on its costs, statistics, and charges for its past, current, and budgeted fiscal years, using a uniform accounting and reporting system. This data is used to develop screens for a budget review.

Hospitals are clustered into peer groupings which are developed after considering: size, teaching level, case mix, and geographic location. The operating budget is first reviewed on a global level using primary screens. Primary screening consisting of reviewing budgeted total operating expenses, cost per patient day, cost per admission, and the percentage change from base to budget year for each of those items. In order to pass a screen the facility must be at or below the 70th percentile for its peer group. If the facility passes all screens its proposed operating expenses are approved. If it fails any one screen a secondary screening process is initiated.

The secondary screening consists of a cost center by cost center review. In order to pass a screen the facility must be at or below the 70th percentile for its peer group. If a cost center passes a screen no further review is required. If a cost center fails a screen, staff performs a detailed analysis of that cost center. Areas considered include inflation, changes in volume, and uncontrollable costs. In addition to the operating budget, the Capital Expenditure budget and Cash Flow budget are reviewed by staff for appropriateness and adequacy considering the facilities' overall financial needs.

After consideration of all of the above, the staff of the Commission develops a schedule of rates for each revenue center which will allow the facility to meet its financial needs. The facility utilizes these rates in establishing its list of charges.

The amount of incentive or risk and the method, if any, of retroactive adjustment varies dependent upon which of three groupings a hospital is in as part of a current experiment (see Developmental Activities below).

HEARINGS/APPEALS:

The staff of the Commission must submit its findings to the hospital at least 15 days prior to an informal hearing before the Commission. At this hearing the facility may present evidence which it feels justifies adjustments beyond those recommended by the Commission staff.

If a hospital is dissatisfied with the decision of the Commission after the informal hearing, it may appeal to the Commission for a formal hearing of record. This formal hearing would be conducted by either a member of the Commission or an independent hearing officer at the Commission's option.

If the facility is dissatisfied with the results of the formal hearing it has recourse to the courts.

DEVELOPMENTAL ACTIVITIES:

Under HCFA Contract No. 600-76-0170 all hospitals have been assigned on a random basis to one of three groups. All three groups go through the existing prospective rate setting system. The differences between groups is the method of payment and the resultant incentives.

For the first group of hospitals the Commission sets a total revenue figure which is used to establish charges to all payors (including Medicaid, Blue Cross, and Medicare). There are no cost settlements or retroactive volume adjustments. If a facility spends more than the approved revenue it is at risk for the excess cost and if it spends less than anticipated it keeps the excess revenue.

The second group of hospitals are reimbursed at an approved rate per unit of service as with the existing (third group) system. However, for this group the rates apply to Medicaid, Medicare, and Blue Cross as well as other charge-based payors.

The third group of hospitals continue under the existing system whereby prospective rates apply only to private pay and commercial insurers, while Blue Cross, Medicaid, and Medicare reimburse retrospectively based on costs.

Hospitals in all reimbursement groups are subject to a compliance review. This compliance review is done utilizing audited financial reports plus revenue information. After adjustments for volume and payor-mix any revenue determined to be in excess of the needs expressed in the budget is applied against next year's revenue.

The purpose of this three cell reimbursement experiment is to assess the difference in expenditures resulting from the alternate methods of reimbursement. In addition, the Commission is further developing its case mix methodology, refining the screening techniques used in the budget review process, and re-examining the cluster analysis techniques utilized in its grouping methodology.

PENDING LEGISLATION: None

CONTACT FOR ADDITIONAL INFORMATION:

Executive Director
Washington State Hospital Commission
206 Evergreen Plaza Building
711 South Capitol Way
Olympia, Washington 98504

STATE: Wisconsin

STATUTE: Section 49.45, Section 146.60 Wisconsin Statute;
Chapter 39, Wisconsin Laws of 1975, Chapter 224
Wisconsin Laws of 1976

DATE: 1975

PURPOSE: Allow reimbursement of hospital costs to be determined prospectively, in order to provide incentives for cost containment.

AGENCY: Wisconsin Hospital Rate Review Committee

By statute prospective rates may be established directly by the Department of Health and Social Services or through a mutual agreement with the Wisconsin Hospital Association and Blue Cross of Wisconsin. The State has chosen the latter approach.

Under the three party agreement an independent Rate Review Committee was established composed of 20 members; 6 appointed by the Governor, 6 appointed by the hospital association; 6 appointed by Blue Cross, and 2 appointed jointly by the State and the hospital association. Authority to decide on the reasonableness of rates rests with the Rate Review Committee. Actual budget analysis is performed by the staff of Blue Cross, and technical support for developing methodology by the staff of the Department of Health and Social Services.

FACILITIES:

Mandatory participation and compliance by all nonfederal hospitals.

PAYORS COVERED: All payors except Medicare

CURRENT PROGRAM:

Hospitals must notify the Committee of any change in rates 60 days prior to the proposed implementation date. Forty-five days before changes take effect hospitals must file the following: operating budget (current and prospective) interim income statement, balance sheet, capital equipment and expenditure budget, debt schedule, audited financial statement, additional revenue requested by the department. A uniform accounting and reporting system is not used, rather Blue Cross staff transfers the hospital data to its own format for internal analysis.

Hospitals are grouped considering geographic location, size, and teaching activity. Within these groups hospitals are evaluated on the following items: percent of occupancy, length of stay, employees per patient day, average salary per employee, days of revenue in accounts receivable, days of costs in inventory revenue per diem, financial requirements per diem, total revenue per diem, operating expenses per diem, charge per admission, and per diem cost of research and educational programs.

The facility has the opportunity to justify any above-average costs. Items not justified may be removed from the operating budget.

In addition to establishing a reasonable level of operating expenses the following items are considered in determining the overall financial needs: costing differences, capital requirements, debt service cash flow.

Requested revenues are compared to the overall financial requirements as determined by the above review. The staff then makes a recommendation to the Rate Review Committee to accept, reject, or modify the proposed charges.

A hospital may only request a change of rates once per year and there are no retroactive adjustments. During the year, however, a second change of rates may be requested for unusual or unforeseen circumstances.

HEARINGS/APPEALS:

If a hospital disagrees with the recommendations of the staff, it may present its position before the Rate Review Committee. If the hospital is dissatisfied with the decisions of the Committee it may appeal to a independent seven member Appeals Board. The findings of the appeals board are binding.

DEVELOPMENTAL ACTIVITIES:

As part of the agreement establishing the Rate Review Committee a Standards Development Committee was created. Supported by staff from the Department o Health and Social Services, the Committee is in the process of refining the criteria used in the budget review process.

PENDING LEGISLATION: None

CONTACT FOR ADDITIONAL INFORMATION:

Deputy Director
Bureau of Health Care Financing
Department of Health and Social Services
One West Wilson Street
Madison, Wisconsin 53702

GLOSSARY

The headings, as they appear in each abstract, are used in the following context:

STATUTE refers to the name and number of the State legislation.

DATE refers to the date of passage of the enabling legislation.

PURPOSE refers to the stated intent of the legislation.

RESPONSIBLE AGENCY refers to the organization or State agency responsible for carrying out the legislation and also includes a brief description of the lines of responsibility and the relationship of related panels and committees.

FACILITIES COVERED refers to type of health care organization covered by the legislation.

PAYORS COVERED refers to purchasers, both private and third party, directly affected or covered by the legislation.

CURRENT PROGRAM refers to the system currently operated under the existing legislation. Among the items considered are: frequency of review, reporting requirements, screening methods, use of inflation indices, volume and other adjustments, risks and incentives.

HEARINGS/APPEALS refers to the mechanism for contesting decisions or resolving disputes.

DEVELOPMENTAL ACTIVITIES refers to research activities to refine and improve the current program.

PENDING LEGISLATION refers to pending bills which would result in substantive changes to the operation or scope of the current program.